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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Matthew Thomas Siedhoff, M.D.** **8635 W 3rd St, Suite 160** **Los Angeles, CA 90048** **Physician's and Surgeon's Certificate No. C 138819,** Respondent.	Case No. 800-2020-070379 **A C C U S A T I O N**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 9, 2015, the Medical Board issued Physician's and Surgeon's Certificate Number C 138819 to Matthew Thomas Siedhoff, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2023, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise

indicated.

STATUTORY PROVISIONS

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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COST RECOVERY

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS

8. Respondent practices obstetrics and gynecology ("OBGYN") and has performed minimally invasive gynecologic surgery ("MIGS") since in or around 2021.

9. On or about October 24, 2018, Respondent first saw Patient 1[1] for a consultation regarding endometriosis and severe pelvic pain. Patient 1 had a significant history of prior surgeries that included two previous cesarean sections, a miscarriage, a hysteroscopy, a dilation and curettage, a polypectomy, a right ovarian cystectomy, a left ovarian cystectomy, a fulguration of endometriosis, a hysterectomy, and a bilateral salpingo-oophorectomy. Respondent believed Patient 1's pain was probably not secondary to endometriosis due to her pelvic extirpation. Nonetheless, after reviewing her history, Respondent offered a repeat operative laparoscopy to remove any possible residual endometriosis. Respondent diagnosed Patient 1 with centralized pain syndrome with peripheral contributors of dysmenorrhea and heavy bleeding (treated), endometriosis, musculoskeletal and GI contributions.

10. On or about May 2019, Patient 1 decided to proceed with the operative laparoscopy surgery which was then scheduled for August 29, 2019. Patient 1 also desired an appendectomy and cystoscopy.

11. On or about August 20, 2019, Respondent entered a pre-operative history and physical for Patient 1 into the electronic health record. The physical portion did not indicate that Respondent ever examined Patient 1 beyond what was observed at the physical consultation ten months prior. During the subject interview on May 3, 2022, Respondent admitted that he did not document the location of Patient 1's pain during his physical examination of the patient. Respondent also admitted that he did not conduct an examination of Patient 1's abdomen or pelvis prior to performing surgery on her abdomen and pelvis. Additionally, there is no evidence that a resident physician or an advanced trained clinician ever conducted an examination of Patient 1's abdomen or pelvis. No clinician examined Patient 1 while she was under general

[1] This patient is referred to by number to respect her privacy.

anesthesia prior to the planned surgical procedure.

12. On or about August 29, 2019, Respondent performed the following procedures on Patient 1: a laparoscopic excision of possible endometriosis, a laparoscopic appendectomy and a cystoscopy. Respondent's operative report ("Operative Report") for the procedure contained a section entitled "the Procedural Detail," which incorrectly stated that "a RUMI uterine manipulator was secured in the uterus" of Patient 1, despite Patient 1's lack of a uterus. Further, Respondent's findings included an absent uterus, ovaries, and tubes, as well as normal GI organs, a normal appendix, filmy adhesions, and a normal cystoscopy.

13. The "Procedure Detail" also contained no mention of a cystoscopy despite the fact that it was listed as a performed procedure in Respondent's Operative Report.

14. The subsequent pathology report showed left uterosacral focal stromal endometriosis and an appendix with no significant abnormalities. However, the report also indicated that the submitted appendix specimen was disrupted and received as two separate pieces. Moreover, the serosa was "remarkable for punctate hemorrhage and areas of wall tearing."

15. On or about August 30, 2019, Patient 1 called Respondent's office to report blood on her gauze. Respondent told the patient that as long as the blood was not bleeding through the bandage, there was "nothing to do." (Documented telephone encounter in Cedars Sinai system signed by Respondent on August 30, 2019 at 11:27 am.)

16. On or about August 30, 2019, Patient 1 messaged Respondent via the patient portal to ask if there was anything stronger than hydrocodone that she could take for her pain.

17. On or about September 4, 2019, Patient 1 called Respondent's office to complain about more pain and cramping that she felt. On or about September 5, 2019, Respondent provided her with a prescription refill for the Norco, and then told the patient on or about September 6, 2019 that there would be no more refills.

18. On or about September 11, 2019, Respondent conducted a postoperative telephonic patient encounter with Patient 1. Respondent suggested to Patient 1 that she see a pain medicine specialist, but did not make a referral. Instead, he told her that he "would have been happy to if it was necessary."

19. Later that day on or about September 11, 2019, Patient 1 suffered symptoms and went to an emergency room at a health care facility. She underwent imaging studies which showed a "stump appendicitis" for the first time. (Documented telephone encounter in Cedars Sinai system signed by Respondent on September 20, 2019 at 7:56 am.)

20. On or about September 20, 2019, Patient 1 messaged Respondent six times in the early morning hours with multiple complaints, including that she felt "confused, frustrated, disheartened, angry . . . [, and that she was n]ot sure what to think . . . [and that her] cramping symptoms continue." Respondent considered these complaints and looked at Patient 1's imaging studies, but concluded that the results failed to support any clinically meaningful stump appendicitis.

21. During the subject interview on May 3, 2022, Respondent admitted that he had never come across "a situation of stump appendicitis." (Subject interview transcript, pg. 34, lines 12-15.) Despite his inexperience, Respondent failed to seek any consultation with another physician regarding the stump appendicitis. Respondent also failed to offer to further examine or evaluate Patient 1. On or about September 20, 2019, Respondent received a message from Patient 1 regarding her CT scan. Respondent told Patient 1 that surgery was unwarranted based upon his interpretation of the initial CT scan.

22. On or about September 20, 2019, Respondent met with Patient 1 for the final time, and told Patient 1 that he had nothing left to offer her, and that her clinical presentation was beyond his expertise. He also told her to find a gastroenterologist and pain specialist to care for her. However, Respondent did not offer Patient 1 a referral to another doctor to resolve her complication of a stump appendicitis.

23. On or about September 23, 2019, Patient 1 went to Palomar Medical Center's emergency room with complaints of a recurrence of her right lower quadrant pain symptoms. Another CT scan was performed on her and the results showed a persistent inflammatory reaction on her appendix. The treating physician noted that Patient 1's stump appendicitis was improving, but needed close follow-up attention.

24. On or about September 27, 2019, Patient 1 saw Dr. M. S., a general surgeon, to

address her complaints of a stump appendicitis.

25. On or about October 16, 2019, Dr. M.S. performed a laparoscopic distal cecectomy. The surgical pathology report indicated that she had a stump appendicitis with a hemorrhage and inflammatory reaction.

26. On or about November 6, 2019, Patient 1 was seen postoperatively, and she reported that her previous medical complaints had completely resolved.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

27. Respondent Matthew Thomas Siedhoff, M.D. is subject to disciplinary action under Code section 2234, subdivision (b) in that he was grossly negligent in connection with the care and treatment of a patient. The circumstances are as follows:

28. The allegations of Paragraphs 8 through 26 are incorporated here as if fully set forth.

29. Respondent committed gross negligence when he:

a. Failed to examine Patient 1's abdomen and pelvis prior to performing a laparoscopy for possible endometriosis and pelvic pain; and

b. Failed to provide and ensure a direct referral for Patient 1 to help resolve her post-operative complication of a stump appendicitis.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

30. Respondent Matthew Thomas Siedhoff, M.D. is subject to disciplinary action under Code section 2234 subdivision (c) in that Respondent committed repeated negligent acts. The circumstances are as follows:

31. The allegations in the First Cause for Discipline are incorporated herein as if fully set forth. Each of Respondent's acts and/or omissions as set forth in the First Cause for Discipline, individually, collectively, or in any combination thereof, constitutes negligence.

32. In addition, Respondent committed negligence when he:

a. Failed to offer any sufficient reevaluation of Patient 1 postoperatively despite the clear indication that the patient was in pain, distressed, and confused;

b. Withdrew from care of Patient 1 without an appropriate in-person examination of the patient. Because he deemed that Patient 1's clinical condition was not emergent, Respondent minimized a complication he had never previously encountered and was dismissive of the patient's documented pain and presenting condition;

c. Failed to adequately and accurately document a cystoscopy description performed during the surgery on Patient 1; and

d. Failed to adequately and accurately document the placement of a uterine manipulator in Patient 1 when the uterus had previously been removed.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate and Inadequate Record Keeping)

33. Respondent Matthew Thomas Siedhoff, M.D. is subject to disciplinary action under Code section 2266 in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to a patient. The circumstances are as follows:

34. The allegations of the First and Second Causes for Discipline are incorporated herein by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 138819, issued to Matthew Thomas Siedhoff, M.D.;

2. Revoking, suspending or denying approval of Matthew Thomas Siedhoff, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Matthew Thomas Siedhoff, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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5. Taking such other and further action as deemed necessary and proper.

DATED: AUG 17 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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